09173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 237

1. PLACE OF DEATH

County: P. Geo

City or town: Aquasco Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: P. Geo

City or town: Aquasco Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas [redacted] Adams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10 - 1858

8. AGE: Years	Months	Days	If less than one day
87	2	24	..... hrs. ..... min.

9. Birthplace Charlotte Hall Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Mckinnon

13. Birthplace

MOTHER 14. Maiden name: Sallie Dade

15. Birthplace: Chas Co Md

16. Informant: Samuel Adams

Address: 1812 - Vernon St Nork Dk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-6-45 (month) (day) (year)

Cemetery or crematory: John Wesley

Location: Aquasco Md

18. Funeral director: Smith & Royston

Address: Waldorf Md

19. Sept 5 1945 M. L. Moore Registrar (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1945 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14, 1945, to Sept. 3, 1945

and that I last saw him alive on Sept. 2 1945

Immediate cause of death	DURATION
(a) Chronic myocardial degeneration	P
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dan S. Fisher M.D. per Jno. L. Mackenzie M.D. M. D. or other

Address: Hughesville, Md. Date signed 9-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09174

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Beverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week.

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 32 Poplar ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Elizabeth Carroll Allard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Married

6.(b) Name of husband or wife: William Clinton Allard

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): June 27, 1866

8. AGE:

Years	Months	Days	If less than one day
79	2	19	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Hanson ?

13. Birthplace: Maryland

MOTHER

14. Maiden name: Carroll ?

15. Birthplace: Maryland

16. Informant: William Clinton Allard Jr.

Address: 813 Richmond ave Silver Spring

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 17 1945 (month) (day) (year)

Cemetery or crematory:

Location: 254 Carroll St Post Dc

18. Funeral director: Wilbur Walters

Address: 254 Carroll St. N.W. Tak. Park D.C.

Sept 17 1945 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 1945 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1945 to Sept 16 1945 and that I last saw her alive on Sept 16 1945

Immediate cause of death	DURATION
General Carcinomatosis	8 mos.
Primary site: Not known.	
Due to: Duration: not known. cwp	
Previous operation, in may, 1945, showed	
Due to: metastasis to Liver.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Metastasis to Liver

Date of op. May 1945

Autopsy results: Consent for an autopsy refused.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. W. Malin M.D. M. D. or other

Address: Beverdale, Md Date signed: 9-16-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

09175

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince George's

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Claudette K Belt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1945

8. AGE: Years | Months 2 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace Upper Marlboro, Md (Town, county, and state)

10. Usual occupation home

11. Industry or business

FATHER 12. Name Samuel Belt

13. Birthplace Maryland

MOTHER 14. Maiden name Susan L Selmon

15. Birthplace Maryland

16. Informant Samuel Belt

Address Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 (month) 10 (day) 45 (year)

Cemetery or crematory Mt Carmel

Location Upper Marlboro, Md

18. Funeral director Ritchie Brothers

Address Upper Marlboro, Md

19. Sept 10 1945 (Date rec'd by registrar) R Clyde Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1945, at 8-20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945 to Sept 8 1945

and that I last saw h.. alive on Sept 3 1945

Immediate cause of death	DURATION
Exhaustion, Duration	
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

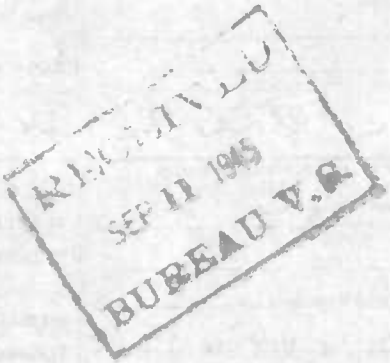
23. SIGNATURE James D Ford M. D. or other

Address Forestville Md Date signed 9-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


SEP 11 1945
BUREAU V.S.

Evidence for the change of age is shown on

09176

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

File No. G 98 OCT 25 1945

Reg. Dist. No. 234

1. PLACE OF DEATH:
County Prince Georges
City or town Accokeek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred:
Route # 224
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Accokeek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Bennett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Mary Bennett
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15 1892

8. AGE: Years	Months	Days	If less than one day
53 52	7	8	hrs. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Clarence Bennett
13. Birthplace South Carolina

MOTHER
14. Maiden name Lenhan
15. Birthplace Lenhan

16. Informant Mary Palmer Bennett
Address Accokeek Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26 1945 (month) (day) (year)
Cemetery or crematory Mt. Country
Location Pomonkey
18. Funeral director Hurtt & Tyson
Address Hadley Md

19. 10-4 1945 Mrs Allen Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945 at 1:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Crushed chest Large laceration	
Due to Head	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 9-23-45
Where did injury occur? Accokeek P.O. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 224
Means of injury Hit by car in collision Injured at work?
Deputy Medical Examiner

23. SIGNATURE Wm. J. Ford M. D. or other
Address Forestville Md Date signed 9-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48

CERTIFICATE OF DEATH

19177

★ Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Hillside Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4900 O St S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: HELEN IONE BERKHEIMER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Dale E. Berkheimer
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 13 1907

8. AGE:	Years	Months	Days	If less than one day
~~38~~	38			..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Clerk.
11. Industry or business: U. S. Govt.

FATHER
12. Name: William Walker Giles
13. Birthplace: Va.

MOTHER
14. Maiden name: Gertrude J. Fields.
15. Birthplace: Va.

16. Informant: Mr. Dale E. Berkheimer
Address: 4900 O St S.E. Hillside Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-18-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St S.E.

19. Filed Sept 19 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1945 at 10:15 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1944, to Sept 15 1945 and that I last saw h[illegible] alive on September 15 1945

Immediate cause of death	DURATION
Carcinoma	14 months
Due to, or as a consequence of: metastases	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William Brannin M.D. M. D. or Coroner
Address: Capitol Heights Md. Date signed 9/15/45

09178

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1952)

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Prince George General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Sylvester Binger, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Bessie Sweeney Binger
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 30 - 1920.

8. AGE:

Years	Months	Days	If less than one day
24	0	9	hrs. min.

9. Birthplace Upper Marlboro Pr. Geo Co. Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Charles S. Binger, Sr.
13. Birthplace Pr. Geo. Co. Md

MOTHER
14. Maiden name Verna Mae Webb
15. Birthplace Montgomery Pennsylvania

16. Informant Mrs Hazel B. Moore
Address Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9-45 (month) (day) (year)
Cemetery or crematory Trinity
Location Upper Marlboro Md.
18. Funeral director Fletcher Bros.
Address Upper Marlboro, Md.

19. 9/9 (Date rec'd by registrar) 1945 Amanda Laurence Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6 1945, to Sept 9 1945
and that I last saw h[illegible] alive on September 6 1945

	DURATION
Immediate cause of death Compound Fracture of Skull with	3 days
Due to Hemorrhage.	
Due to	
Other conditions Oedema of Brain	3 days

(Include pregnancy within 3 months of death)

Major findings of operations Brain Injury Date of op. 9-7-45
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9-6-45
Where did injury occur? Upper Marlboro (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?) Falling Auto
Means of injury Explosion of Tire Injured at work? No

23. SIGNATURE James L. Jarrett M. D. or other
Address Upper Marlboro Date signed 9-9-45 Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age & birth date of deceased is shown on FILE No. G 98 OCT 11 1945

(9179)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 1 day
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 419 - 8th St. S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bland, Marseiller

3.(b) Social Security Number: 579-34-5576

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ____ years

7. Birth data of deceased (mo., day, yr.): July 16, ~~1895~~ 1903

8. AGE: Years	Months	Days	If less than one day
42 50-	2	8	____ hrs. ____ min.

9. Birthplace: Oklahoma City, Oklahoma (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER
12. Name: Reverand Bland
13. Birthplace: Missouri

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Decedent
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Sept 25 1945 (month) (day) (year)

Cemetery or crematory:
Location: to Wash. D C

18. Funeral director: Barnes & Matthews
Address: 614 - 4½ St. S. W.

19. Sept 24 19 45 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 19 45 at 8 35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-23 19 45 to 9-24 19 45 and that I last saw him alive on 9-24 19 45

Immediate cause of death	DURATION
Pulmonary tuberculosis	18 mos
Due to:	
Due to:	
Other conditions: Syphilis, late, active	10 yrs
Syphilitic pericarditis	3 yrs 6 mos

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09990

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mos., 29 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 5 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1309 - 11th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mattie E. Blue

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Arthur P. Blue

6.(c) If alive, give age: 41 years

7. Birth data of deceased (mo., day, yr.): September 2, 1904

8. AGE: Years	Months	Days	If less than one day
41	-	20	...hrs. ...min.

9. Birthplace: Gastonia, North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Lynn
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Sallie Gladde
15. Birthplace: North Carolina

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Sept. 22 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Martin M. Hyson Co

Address: 1300 N St. N.W. Wash, D.C.

19. Sept. 22 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1945, at 7 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-24 1944, to 9-22 1945

and that I last saw h...r alive on 9-21 1945

	DURATION
Immediate cause of death: pulmonary Tuberculosis	19 mos
Due to:	
Due to:	
Other conditions: tuberculous laryngitis	19 mos

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 9-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0918 243

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos., 30 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 10 mos., 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1006 3rd St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: AUDREY BOWE

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: Frank D. Bowe
6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): December 11, 1925

8. AGE: Years	Months	Days	If less than one day
19	9	15	..... hrs. ..... min.

9. Birthplace: Alexandria, Virginia
(Town, county, and state)
10. Usual occupation: Typist – Gen'l. Accounting
11. Industry or business

FATHER
12. Name: George W. Francis
13. Birthplace: Alexandria, Virginia

MOTHER
14. Maiden name: Vernon Jeffries
15. Birthplace: Marcum, Virginia

16. Informant: Decedent
Address

17. Removal to
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 26, 1945
(month) (day) (year)
Cemetery or crematory
Location: Washington, D. C.
18. Funeral director: Walker & Sellers Inc
Address: 464 R St N W

19. 9/26/ 1945 Rowland & Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 26 1945 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCTOBER 27 1944, to SEPT. 26 1945
and that I last saw h.s.w.ative on SEPT. 26 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	11 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-M)

CERTIFICATE OF DEATH

09182

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 411 Queensbury Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 411 Queensbury Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Julian Upton Bowman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanche B. Bowman

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): May 6, 1907

8. AGE: Years: 38 | Months: 4 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Germantown, Md. (Town, county, and state)

10. Usual occupation: Sportsman

11. Industry or business

FATHER

12. Name: William Upton Bowman

13. Birthplace: Maryland

MOTHER

14. Maiden name: Julia Helen King

15. Birthplace: Maryland

16. Informant: Mrs. Sterling Bowman

Address: Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1945 (month) (day) (year)

Cemetery or crematory

Location: Bethesda, Md.

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Md.

19. Sept. 19, 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19, 1945, at 5-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to: Acute Carbon Monoxide poisoning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide: Suicide Date of: 9-19-45

Where did injury occur? Riverdale (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Turned gas stove on Injured at work? No

Deputy Medical Examiner

23. SIGNATURE: [signature] M. D. or other

Address: Forestville, Md. Date signed: 9-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

09183

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges Co.
City or town Landover Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Neb. County
City or town Ralston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7723 Eastwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Mary Catherine Brazda. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife James J. Brazda
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept 28 - 1869

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

8. Birthplace Czechoslovaska (Town, county, and state)
10. Usual occupation House wife
11. Industry or business
FATHER 12. Name John Pecha.
FATHER 13. Birthplace Czechoslovaska.
MOTHER 14. Maiden name ?
MOTHER 15. Birthplace
16. Informant Mrs Frances Whitley
Address 6500 Landover Rd Landover Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 29 1945 (month) (day) (year)
Cemetery or crematory
Location 641 H. St. N.E. Washington D.C.
18. Funeral director Albert Bosh
Address 641 H St N.E. Washington D.C.
19. Sept. 28 1945 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1945 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Sept 28 1945
and that I last saw h[illegible] alive on Sept 28 1945

Immediate cause of death	DURATION
Carcinoma of Gall Bladder & Metastasis to Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Carcinoma of Gall Bladder & Liver Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert Bosh M. D. or other
Address Hyattsville, Md. Date signed 9-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

2148

09184

Reg. Dist. No. 245

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Leland Memorial Hosp.
How long in hospital or institution? 15 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4911 Ravenswood Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Philip Briggs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife: Anna Catherine Briggs
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Aug 21, 1876

8. AGE:	Years	Months	Days	If less than one day
	71	0	18	hrs. min.

9. Birthplace: Freeport Maine (Town, county, and state)
10. Usual occupation: Lawyer.
11. Industry or business: U.S. Govt
FATHER 12. Name: Oliver Derrick Briggs
13. Birthplace: Unknown.
MOTHER 14. Maiden name: Ann Koopman
15. Birthplace: Freeport Me.
16. Informant: Mrs James Briggs
Address: 4911 Ravenswood Rd, Riverdale
17. (Burial, cremation, or removal. Which?) Date thereof: 9-11-45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.
18. Funeral director: W W Chambers
Address: Riverdale, Md.
19. 9-9-45 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 19 45 at 7 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Cardio-vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner
M. D. or other
Address: Forestville Md. Date signed: 9-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09185

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: Glenn Dale, Maryland - RURAL (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 28 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium, Glenn Dale, Md

How long in hospital or institution? 4 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No.: 636- K. St., N.E. (If rural, give LOCATION)

2. (a) If veteran, name war: World War I. 9/ 1917 - July 1919

3. (a) FULL NAME: Charles M. Brown

3. (b) Social Security Number: 577-5-6277

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife: Effie M. Brown

6. (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 18, 1887

8. AGE:	Years	Months	Days	If less than one day
	58	3	15	... hrs. ... min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Clerk- Supply Office, War Dept.

11. Industry or business: -

FATHER

12. Name: John L. Brown

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary L. Miles

15. Birthplace: Maryland

16. Informant: deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Albert J. Ashe

Address: 641 - H. St. N.E.

19. Sept. 2 1945 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 1945, at 10 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/5 1945, to 9/2 1945

and that I last saw him alive on 9/2 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	8 mos 5 da
Due to:	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 9/2/45

Evidence for change of age is shown on FILM No. G98 OCT 4 1945

09185

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days.
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium, Md.
How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ____ County: ____
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Florida Ave. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Willie Burton

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Mrs. Eula Burton nee Mason
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 1-5-97

8. AGE: Years	Months	Days	If less than one day
54 52	8	1	...hrs. ...min.

9. Birthplace: Newberry, S. Carolina (Town, county, and state)
10. Usual occupation: Laborer in Navy Yd.
11. Industry or business:

FATHER
12. Name: Thomas Burton
13. Birthplace: Newberry, So. Car.

MOTHER
14. Maiden name: Emma?
15. Birthplace: same

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: A B Boyd
Address: 1238 20th St NW

19. Sept. 7 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-7 1945, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-30 1945, to 9-7 1945
and that I last saw h. i.m. alive on 9-7 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis for Advanced	8 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

09187

Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4837 - 3rd St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: HENRY CARPENTER

3.(b) Social Security Number: 579003-6173

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 3, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	27	hrs. min.

9. Birthplace: Achsah, Virginia (Town, county, and state)

10. Usual occupation: Landscape Gardner

11. Industry or business:

FATHER — 12. Name: Ellie Carpenter

13. Birthplace: Acsah, Virginia

MOTHER — 14. Maiden name: Mary Carpenter

15. Birthplace: Acsah, Virginia

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 30, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Barnes & Matthews

Address: 614 - 4th St. S. W.

19. Sept. 30, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 1945 at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from (S.T.) Sept 26 1945, to Sept 30 1945:

and that I last saw h.. living on Sept. 29 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mo.
Due to:	
Due to:	
Other conditions: Cardiac decompensation - 1 mo. secondary to pulmonary tuberculosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Bilateral pulmonary tuberculosis and chronic passive congestion of liver, splenic hyperplasia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: dilatation of right ventricle

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.

M. D. or other

Address: Glenn Dale, Md. Date signed: 9/30/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09188

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

★ Reg. Dist. No. 229

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
342 Laurel Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr Geo
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 342 Laurel Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Florence May Cockrell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Irvine F. Cockrell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1880

8. AGE: Years	Months	Days	If less than one day
65	8	20	..... hrs. ..... min.

9. Birthplace: Anne Arundle Co. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles Warfield
13. Birthplace: Anne Arundle

MOTHER
14. Maiden name: Sarah Ann Hands
15. Birthplace: Anne Arundle

16. Informant: Irvine F. Cockrell
Address: 342 Laurel Ave. Laurel, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept. 13, 1945 (month) (day) (year)
Cemetery or crematory: Friendship Cemetery
Location: Severn, Maryland

18. Funeral director: D. Will Dobbelson
Address: 105 Main St. Laurel Md.

19. Sept 12 1945 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/11 19 45 at 6 05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8 19 45 to 9/11 19 45 and that I last saw her alive on 9/10 19 45

Immediate cause of death	DURATION
(a) Asthma Salem	7
Due to: (b) Cerebral Hemorrhage	1
Due to: (c) Chronic Nephritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner
Address: Laurel Date signed 9/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

09189

CERTIFICATE OF DEATH ★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1312 Irving St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: Covington, James A.

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Wanda Covington
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 26, 1895

8. AGE: Years	Months	Days	If less than one day
50	–	16	hrs. min.

9. Birthplace: Rockingham, N. C.
(Town, county, and state)
10. Usual occupation: Cook
11. Industry or business:

FATHER
12. Name: William Covington
13. Birthplace: Rockingham, N. C.

MOTHER
14. Maiden name: Caroline ?
15. Birthplace: Rockingham, N. C.

16. Informant: Decedent
Address:

17. Removal to Wash. D. C. Date thereof: Sept 12 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: L W Chambers & Bro Inc
Address: 1400 Chapin st nw.

19. Sept. 11 1945 Rowland S Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1945 at 10:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 1945 to Sept 11 1945 and that I last saw him alive on Sept 11. 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09190

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

905 - Elm Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 905 - Elm Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Winfield Craver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Ethel Craver

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept 28, 1864

8. AGE: Years	Months	Days	If less than one day
75	11	4	hrs. min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER — 12. Name: Simon Craver

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susannah Stull

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Ethel Craver

Address: Takoma Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5 1945 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Clinton Md

18. Funeral director: Roy W. Barber

Address: Takoma Park Md

19. Sept 4 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1945, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Attempt medical Examiner

23. SIGNATURE: James D. Bard M. D. or other

Address: Forestville Md Date signed 9-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

09191

Reg. Diat. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County Prince George

City or town Laurel Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 924 Montgomery Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Carter Crowmiller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Eucharistic Crowmiller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1893

8. AGE:

Years	Months	Days	If less than one day
51	9	1	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Pumper Mech.

11. Industry or business U.S. Government Navy Yard

FATHER

12. Name John Crowmiller

13. Birthplace Kentucky

MOTHER

14. Maiden name Willie E. Carter

15. Birthplace Irvington, Va.

16. Informant Eucharistic Crowmiller

Address 924 Montgomery Ave Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20, 1945 (month) (day) (year)

Cemetery or crematory Oak Hill

Location Laurel Md.

18. Funeral director Wetherald Funeral Home

Address Laurel, Md.

19. Sept 19 1945 M. Brashears

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18, 1945 at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1 1945, to Sept 18 1945

and that I last saw him alive on Sept 17 1945

Immediate cause of death	DURATION
Acute myocarditis	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

If VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. McEnery M.D.

M. D. or other

Address 49 Main St Laurel Md. Date signed 9/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1945-9-18
1890-12-17

51-9-1

21
14
1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09192

CERTIFICATE OF DEATH

★ Reg. Dist. No. 246

1. PLACE OF DEATH:
County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Four years.
Hospital, Institution, or street address where death occurred: 4220 29th Street.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges.
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4220 29th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Clarence Wilbert Crosby

3.(b) Social Security Number: 577-07-7804

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh.	Married.

6.(b) Name of husband or wife: Elizabeth Meinberg
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	15	....hrs. ....min.

9. Birthplace: Mc Clure, Pa.
(Town, county, and state)
10. Usual occupation: Emergency Service Work.
11. Industry or business: Wash. Gas & Light Co.

FATHER
12. Name: Hiram Crosby.
13. Birthplace: ? Pennsylvania.

MOTHER
14. Maiden name: Lucinda Anthony.
15. Birthplace: ? Pennsylvania

16. Informant: Elizabeth Crosby, Wife.
Address: 4220 29th St., Mt. Rainier

17. Removal — Date thereof: Sept. 28, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: to District of Columbia.
Location: —

18. Funeral director: Geo. W. Wise Co., Inc.
Address: 2900 M St. N.W., Wash., D.C.

19. Sept 28 1945 James Sellers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 1945 at 12:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1945, to Sept. 28, 1945
and that I last saw him alive on Sept. 27, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	5 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James J. Jeffer, M.D.
M. D. or other
Address: 2703 Upshur St. Mt. Rainier, Md.
Date signed: 9/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09193

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Benolia Cummings

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William Cummings

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Aug 30, 1902

8. AGE: Years 43 | Months 1 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace: Michigan (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: William Cummings

Address: Bladensburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 26 1945 (month) (day) (year)

Cemetery or crematory: Union Bethel

Location: T. B. Md.

18. Funeral director: J. B. Johnson

Address: Annapolis Md

19. Sept 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1945 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1945 to Sept 21 1945 and that I last saw her alive on Sept 18 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to: Lobar pneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Bladensburg Md Date signed 9-26-45

L.5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09194

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos.
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ..... County: .....
City or town: Washington DC.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1413 Florida Ave NW.
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: Gayzelle Cunningham

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

6.(b) Name of husband or wife: .....
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1935

8. AGE:

Years	Months	Days	If less than one day
9	11	12	..... hrs. ..... min.

8. Birthplace: Washington, DC.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: .....

FATHER
12. Name: James Cunningham
13. Birthplace: ? South Carolina

MOTHER
14. Maiden name: Irene Paris
15. Birthplace: Staunton, Virginia

16. Informant: Mrs. Gayzelle Camp
Address: 1413 Florida Ave NW.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1945 (month) (day) (year)
Cemetery or crematory: Removal
Location: Wash., D. C.

18. Funeral director: Malvaux & Ichers
Address: 424 – 8 St NW

19. Sept. 7 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 19 45 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 8 19 45 to Sept 7 19 45
and that I last saw her alive on Sept 7 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pincura M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0919-5

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 10 mos., 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs., 10 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 606 H. St. S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Curry, George F.

3.(b) Social Security Number: 577-24-5873

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1923

8. AGE: Years	Months	Days	If less than one day
22	6	8	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Government Clerk
11. Industry or business

FATHER
12. Name: George F. Curry
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Nellie A. Kenney
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address

17. Removal to Wash. D.C. Date thereof: 9-9-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Removal to Washington, D.C.
Location

18. Funeral director: Robert A. Mattingly
Address: 131-11th St. S.E. Wash. D.C.

19. Sept. 9 1945 Rowland & Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1945, at 9 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-6 1942, to 9-9 1945 and that I last saw him alive on 9-9 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 yrs
Due to: Empyema, tuberculous, right	1½ yrs
Due to: Thoracotomy, right	3 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Empyema, tuberculous, right
Date of op.: 6-19-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Piscataway Road

(If rural, give LOCATION)

2.(a) If veteran, name war World War # 2

3.(a) FULL NAME Joseph Anderson Ident

3.(b) Social Security Number 214-20-0119

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 3, 1921

8. AGE: Years 24 | Months 3 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER — 12. Name Joseph Ident

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Watson

MOTHER — 15. Birthplace Maryland

16. Informant Ellsworth Pinckney

Address Clinton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-45 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Tolson Bros

Address Upper Marlboro Md.

19. Sept 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1945 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
asphyxia	
Due to Hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 9-25-45

Where did injury occur? Clinton P.G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Hanging Injured at work? No

Deputy Medical Examiner

23. SIGNATURE ..... M. D. or other

Address Upper Marlboro Md Date signed 9-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44-E)

09197

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Carmody Hills Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: [illegible] D.C. County: [illegible]
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1213 Holbrook St N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Joseph Di Giacomo

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 19-1876.

8. AGE: Years	Months	Days	If less than one day
69	5	16	hrs. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Laborer. Retired
11. Industry or business: Wash. Terminal
12. FATHER — Name: Di Giacomo
13. FATHER — Birthplace: Italy
14. MOTHER — Maiden name: ?
15. MOTHER — Birthplace: Italy
16. Informant: John J. Giacomo
Address: 1213 Holbrook St N.E.
17. (Burial, cremation, or removal. Which?) Date thereof: Sept 8 1945 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemet.
Location: Washington D.C.
18. Funeral director: Albert Pike
Address: 641-H St N.E. Wash D.C.
19. Sept. 6 1945 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1945 at 9:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1945, to September 5 1945
and that I last saw him alive on September 5 1945

Immediate cause of death	DURATION
Hodgkin's Disease	11 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or ~~Other~~
Address: Capitol Heights, Md Date signed: 9/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (132)

CERTIFICATE OF DEATH

09198

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 9 mos., 17 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 yrs., 9 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1444 W. Street N. W. #22
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Nathaniel Dowdle

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1927

8. AGE: Years	Months	Days	If less than one day
18	5	10	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: Nathaniel Dowdle
13. Birthplace: Gaffney, South Carolina

MOTHER
14. Maiden name: Susie Jolly
15. Birthplace: Gaffney, South Carolina

16. Informant: Decedent
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof Sept 19 1945 (month) (day) (year)

Cemetery or crematory:

Location: Wash. D.C.

18. Funeral director: Frazier Funeral Co

Address: 389 R I Ave NW

19. Sept 19 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2 1940, to 9-19 1945

and that I last saw h[illegible] alive on 9-19 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 yrs
Due to:	
Due to:	
Other conditions: Pneumoperitoneum	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 9-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

09199

Reg. Dist. No. 24-223

1. PLACE OF DEATH:

County: Prince George's

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

6313 - Carter Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6313 - Carter Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edwin Dwyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife: Helen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 22 1857

8. AGE: Years	Months	Days	If less than one day
87			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Stone Mason Retired

11. Industry or business

FATHER — 12. Name: Henry Dwyer

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Catherine Benson

MOTHER — 15. Birthplace: Maryland

18. Informant: Mrs. Anna La Fourcade

Address: 6313 Carter Ave

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)

Cemetery or crematory: Mt. Hope

Location: Washington D.C.

18. Funeral director: W.W. Chambers Co.

Address: 1400 Chapin St. N.W.

19. Sept 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Senile Congestive Heart Failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner J. J. Sonnel M. D. or other

Address: Forest Glen Md. Date signed 9-4-45

Mrs. Jos. Lesser
4304 Fairfax St

09200

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 hrs.
Hospital, institution, or street address where death occurred:
Prince George Hospital
How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo.
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 75th Harriet Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Mary Ficco

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband ~~or wife~~ Nicola Ficco 6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept. 10th 1899

8. AGE: Years	Months	Days	If less than one day
46	—		..... hrs. ..... min.

9. Birthplace Chicago (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Zakuciya
13. Birthplace Russia

MOTHER 14. Maiden name Elizabeth Kolbacke
15. Birthplace Russia

16. Informant Husband
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1945 (month) (day) (year)
Cemetery or crematory Washington Natl.
Location Washington, D.C.

18. Funeral director J. William Lee & Sons.
Address 300. 4th st N.E. D.C.

19. 9/27 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1945 at 10:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 1945 to Sept. 27 1945
and that I last saw h.. alive on Sept. 27 1945

	DURATION
Immediate cause of death	
Due to	
Due to Carcinoma of colon	
Other conditions Partial intestinal obstruction & toxemia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Binning MD
M. D. (address)
Address Date signed

Evidence for change of year of birth of deceased is shown on

FILM No. G 98 OCT 4 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

~ 09201

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenmont Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address, where death occurred:

1211 Eastern Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Glenmont Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1211 Eastern Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carrie B. Fisher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Howard Fisher

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 4, 1-8-9-8 1899

8. AGE: Years 46 | Months 6 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER 12. Name: Green Powell

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Virginia

16. Informant: Howard Fisher

Address: 1211 Eastern Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17/45 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: D. C.

18. Funeral director: J. B. Simpson

Address: Annapolis

19. Sept. 16 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 19 45; at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Congestive heart failure	
Due to: Cardiac vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Westville Md. Date signed: 9-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

(9202) Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chemistry, Hattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 1/2 mos.
Hospital, institution, or street address where death occurred:
Prince Geo. Gen Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo.
City or town: Forestville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edgar Flowers

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Mrs Edna Flowers (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.): Sept 8, 1879

8. AGE: Years	Months	Days	If less than one day
67			....hrs. ....min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER 12. Name: Thomas Flowers

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Angeline Adams

MOTHER 15. Birthplace: Md.

16. Informant: Mrs

Address: 409 Jo-place Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9-45. (month) (day) (year)

Cemetery or crematory: Forestville Methodist

Location: Forestville, Md "

18. Funeral director: Pitkin Bros.

Address: Upper Marlboro Md.

19. 9/9 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 1945 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Sept 8 1945 and that I last saw h. alive on Sept 8 1945

Immediate cause of death	DURATION
Coronary Thrombosis acute	24 hrs.
Due to: General Arterio-Sclerosis	Intermit
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul C Van Natta M. D. or other

Address: Washington DC Date signed: Sept 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

CERTIFICATE OF DEATH

09203

Reg. Diat. No. 289

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo.

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 335 Lamptons Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nora Alice Gable

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife George M. Gable

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1884

8. AGE:

Years	Months	Days	If less than one day
61	5	18	..... hrs. ..... min.

9. Birthplace Laurel, Md. Pr. George
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name Williams Newman
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden name Catherine Veld
15. Birthplace Baltimore Maryland

16. Informant Mrs. Alma Steele

Address Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 1945 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Laurel Md. Lyland

18. Funeral director D. Fitz Randolph

Address Laurel, Maryland

19 Sept 9 1945 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 4/12/45 to 9/7/45

and that I last saw h... alive on 9/6/45 19

Immediate cause of death	DURATION
Carcinoma of Pancreas	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. J. Richmond M. D. or other

Address Laurel Date signed 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09204

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pro Geo County
City or town: Bladensburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Bladensburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4008 - 48 th st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Florence Estella Gasch

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: F Headley Gasch
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1896

8. AGE: Years: 49 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Eugene Windsor
13. Birthplace: Md

MOTHER
14. Maiden name: Fannie Ferguson
15. Birthplace: Md

16. Informant: Headley Gasch
Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: sept 22 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md

18. Funeral director: F Gasch & sons
Address: Hyattsville Md.

19. 9/24/45 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 19 45 at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44 to Sept. 20 19 45 and that I last saw h.er alive on Sept 20 19 45

	DURATION
Immediate cause of death: Uremia	6 Mo.
Due to: Cardio vascular renal disease	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L W. Malin M.D.
M. D. or other
Address: Riverdale, Md. Date signed: 9-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-7R)

CERTIFICATE OF DEATH

★ Reg. Dist. No. (9205) 239

1. PLACE OF DEATH:

County R.F.D. Laurel Md

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Washington DC
(If outside city or town limits, write RURAL and give nearest town)

Street No. 215 - 18th N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lawrence Allen Green

3.(b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 - 1945

8. AGE: Years — | Months 6 - | Days — | If less than one day ...hrs. ...min.

9. Birthplace Florida
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Frank Green

13. Birthplace Ohio

MOTHER 14. Maiden name Dorothy L. Malone

15. Birthplace Washington D.C.

16. Informant Dorothy L. Green

Address 215 - 18th N.E.

17. Burial, cremation, or removal. Which? Burial Date thereof Sept 13 - 1945
(month) (day) (year)

Cemetery or crematory Rumond Md D.C.

Location

18. Funeral director Wm Lees Sons D.C.

Address 300 - 4th N.E. D.C.

19. Sept 13 1945 M Basheare
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 13 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 12 1945 to 9 13 1945 and that I last saw h... alive on 9 12 1945

	DURATION
Immediate cause of death Acute Cardiac Dilitation	1 day
Due to multiple	
Due to Arteriosclerosis	6 mos
Due to Pulmonary Tuberculosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

23. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B S Glassman M. D. or other

Address Laurel Md Date signed 9/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

09206

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: North Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Innocent

Hospital, institution, or street address where death occurred: 40th & Allison Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Riggs Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ruffin William Gross

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 29, 1895

8. AGE: Years: 50 | Months: 8 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Chillum, Md (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER 12. Name: Robert Gross

13. Birthplace: Maryland

MOTHER 14. Maiden name: Annie Williams

15. Birthplace: Maryland

16. Informant: Albert H. Gross

Address: Riggs Road, Hyattsville

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Sept 28, 1945 (month) (day) (year)

Cemetery or crematory: Jarvis Funeral Home

Location: Washington D.C.

18. Funeral director: F. Ellsworth Sons

Address: Hyattsville, Md.

19. 9/28 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1945, at 1:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Gun shot wound	
through chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of: 9-28-45

Where did injury occur? North Brentwood (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Allison Street

Means of injury: Shotgun wound Injured at work? No

23. SIGNATURE: James J. Bond M. D. or other

Address: Forestville, Md. Date signed: 9-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(13-) 09207

★ Reg. Dist. No. 243.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 3 mos., 23da.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 3 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 123- 16th St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME ROBERT ANDREW HANSON

3.(b) Social Security Number 578-20-2466

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ethel Hanson

6.(c) If alive, give age: about 42 years

7. Birth date of deceased (mo., day, yr.): July 18, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	8	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Painter, Cook

11. Industry or business

FATHER 12. Name: Robert G. Hanson

FATHER 13. Birthplace: Wicomico, Maryland

MOTHER 14. Maiden name: Mattie Dunmore

MOTHER 15. Birthplace: Washington, D. C.

16. Informant: Decedent

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 29 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Bladensburg Rd N.E., D.C.

18. Funeral director: Geo. A. Better, Sons

Address: 1203 Walter St. S.E., D.C.

19. Sept. 26, 19 45 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26th 1945, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3rd 1942 to Sept 26 1945 and that I last saw him alive on Sept 26 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs 6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09208

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, Institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5106 - 42nd St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Reese Helm

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 14, 1929

8. AGE:

Years	Months	Days	If less than one day
16	7	15	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: William M. Helm
13. Birthplace: District of Columbia

MOTHER
14. Maiden name: Frances McLeod
15. Birthplace: District of Columbia

16. Informant: Howard R. McLeod
Address: 420 Shepherd St. Chevy Chase

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 1, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md

18. Funeral director: J. Gasch's Sons
Address: Hyattsville Md

19. Oct. 1 1945 James Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1945, at 1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 9-28-45
Where did injury occur: Greenbelt P.G. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Greenbelt Lake
Means of injury: Drowning and drowned in Lake Artificial Lake
Was injury in line of work?

23. SIGNATURE: [signature] M. D. or other
Address: Forestville Md Date signed: 9-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(9209

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Pr. Geo. Gen'l Hospt.

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 51 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Cheverly Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3312 - Bellevieu Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Evelyn A. Herd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Lindsey B.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 12 - 1899

8. AGE:

Years	Months	Days	If less than one day
46			..... hrs. ..... min.

9. Birthplace: Ala. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: George Theeatis

13. Birthplace: New York

MOTHER 14. Maiden name: Emelia Fellens

15. Birthplace: Texas

16. Informant: Mr. Lindsay B. Herd

Address: 3312 - Bellevieu Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 - 10 - 45 (month) (day) (year)

Cemetery or crematory: Arlington Nat'l Cem.

Location: Virginia

18. Funeral director: J. William Leis Sons

Address: 300 - 4th St. NE.

19. 9/7 1945 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/6 1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1941, to 9/6 1945

and that I last saw her alive on 9/6 1945

Immediate cause of death	DURATION
Carcinoma Colon Dia.	
Malnutrition	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. Hagner M. D. or other

Address: 3717 - 34th St. Date signed 9/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-b)

09210

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Prince Geo.

City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
Prince Geo. Gen. Hospt.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Pr. Geo.

City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Johnston, Mrs. Hermine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ~~86~~ years

7. Birth date of deceased (mo., day, yr.) June 5, 1869

8. AGE:

Years	Months	Days	If less than one day
76	3	20	...hrs. ...min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Mering, Mr. Wm.
13. Birthplace Germany

MOTHER
14. Maiden name Sparinger, Sophie
15. Birthplace Germany

16. Informant Brady, Mrs. Jas. S. (Daughter)
Address Bowie, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Sept 28 / 45
(month) (day) (year)

Cemetery or crematory Parkview Chapel

Location Spring Lake Rd. and

18. Funeral director Charles Towne

Address Bladensburg Md.

19. 9/26 19 45 Amelia Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945 at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Sept 25 1945

and that I last saw her alive on Sept 25 1945

Immediate cause of death	DURATION
Medical Asthenia	8 days
Not due to cancer. C.U.K.R.	
Due to Post-operative adhesions	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Funeral M.D. or other

Address Landover Date signed 9/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

09211

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cedar Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, Institution, or street address where death occurred:

6406 - Lee Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Cedar Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6406 - Lee Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Hiers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Mell Hiers

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 64 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER — 12. Name: John Boatwright

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Lutie Boatwright

MOTHER — 15. Birthplace: South Carolina

16. Informant: Lodie Jenkins

Address: 6406 Lee Ave, Cedar Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7 1945 (month) (day) (year)

Cemetery or crematory: Glenmark

Location: S. C.

18. Funeral director: E. B. Johnson

Address: 467 N St. N.W.

19. Sept 7 1945 (Date rec'd by registrar) Irene G. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 19 45 at 1:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Pulmonary edema	
Due to: Congestive heart failure	
Due to: Cardio Vascular renal diseases	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md Date signed: 9-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

09212

Reg. Dist. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Mariens Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Laurel Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Laurel Highland Rt.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edna Belle Hines

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Arthur Hines
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 29 1889

8. AGE: Years	Months	Days	If less than one day
56		23	hrs. ..... min.

9. Birthplace: Howard Co Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: George Farmer
13. Birthplace: Md

MOTHER
14. Maiden name: Billie Holland
15. Birthplace: Laurel Md

16. Informant: Mrs Ray Hines
Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23 1945 (Month) (day) (year)
Cemetery or crematory: Emmanuel Cem
Location: Scaggsville Md

18. Funeral director: Dr. Lillie Longsdorf
Address: 105 Main St Laurel Md

19. Sept 22 1945 M. Brashears Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 19 45 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 20 1945 to 9 21 1945 and that I last saw her alive on 9 21 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Coronary Sclerosis	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. Adams M. D. or other
Address: Laurel Md Date signed: 9 22 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

09213

CERTIFICATE OF DEATH

★ Reg. Diat. No. 230

1. PLACE OF DEATH:
County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Baltimore Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emmett Mitchell Houlihan

3.(b) Social Security Number 226-05-9387

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22, 1882.

8. AGE: Years 63 | Months 3 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Michael Holihan
13. Birthplace Ireland

MOTHER 14. Maiden name Melinda Fleres
15. Birthplace Virginia

16. Informant Charles P. Houlihan
Address Baltimore Blvd, Berwyn, Md

17. Burial, cremation, or removal. Which? transportation Date thereof Oct 3, 1945. (month) (day) (year)
Cemetery or crematory Catholic Cemetery
Location Mustoe Va

18. Funeral director F. Gasch's Sons
Address Gaithersburg Maryland

19. Oct 3 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Compound fracture Tibia & Fibula Comminuted fracture of left leg	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? accident Date of 9-30-45
Where did injury occur? Berwyn P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury Pedestrian struck by car
Injured while on duty? no

23. SIGNATURE Johnson D. Long M. D. or other
Address Forestville, Md Date signed 9-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

09214 Reg. Diat. No. 342

1. PLACE OF DEATH:
County Prince Georges
City or town 3 Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Thomas Huntt

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Olivia Huntt
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Mch 16 - 1878
8. AGE: Years 67 Months 5 Days 15 If less than one day ..... hrs. ..... min.
9. Birthplace Fairfax Co - Va (Town, county, and state)
10. Usual occupation Cable Splicer
11. Industry or business
FATHER 12. Name Ogie B. Hunt
13. Birthplace Fairfax - Va
MOTHER 14. Maiden name Sylvania Stewart
15. Birthplace Fairfax Co - Va
16. Informant Mrs Violet Blakney
Address 309 - 6th St - Cap Heights
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 - 45 (month) (day) (year)
Cemetery or crematory Brown Chapel Va
Location
18. Funeral director W. W. Chambers Co.
Address 517 - 11th St - S. E. Wash D. C.
19. 9-1 1945 (Date rec'd by registrar) Irene A. Comer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 1 1945 at 3 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 - 29 1945, to 9 - 1 1945
and that I last saw him alive on 9 - 1 - 1945

Immediate cause of death	DURATION
Cerebral Contusion & Hemorrhage	4 Hours
Due to Coma	
Due to Alcoholism	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur H. Melroy M. D. or other
Address 4400 Bunker Hill Date signed 9-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09215

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 2 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 807 - 2nd Street N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Elizabeth Josey

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 21, 1930

8. AGE: Years	Months	Days	If less than one day
15	-	1	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: Robert Josey
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Irene Nero
15. Birthplace: Sumter, South Carolina

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.

18. Funeral director: Gawler Memorial Funeral Home
Address: 29 - H. ST NW.

19. Sept 22 45 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1945 at 4 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-20 1945 to 9-22 1945
and that I last saw h[illegible] alive on 9-21 1945

Immediate cause of death	DURATION
pulmonary tuberculosis	5 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

09216

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 days

Hospital, institution, or street address where death occurred: Leland memorial Hospital.

How long in hospital or institution? 60 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D C County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1236 - E St N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Effie Mae Kerper

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W.	widowed.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2d, 1868

8. AGE: Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: Home

FATHER — 12. Name: Thomas Robertson

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Elizabeth L. Lewis.

MOTHER — 15. Birthplace: Wash. DC.

16. Informant: Hospital Records.

Address: Riverdale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Marylands.

18. Funeral director: Neal Funeral Home

Address: 4812 Ga. Ave. N.W. Wash. D.C.

19. Sept 15 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1945, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1945 to Sept 15 1945 and that I last saw h. alive on Sept 15 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	1 mo.
Due to General Arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. W. Malin M.D. M. D. or other

Address: Riverdale, md Date signed: 9-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

09217

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheberly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 minutes.
Hospital, institution, or street address where death occurred:
Prince George General Hosp.
How long in hospital or institution? 5 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George.
City or town: West Lanham Hills
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7750 Emerson Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Etta Gertrude Koenig

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John Clifton Koenig. 6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 11 1891

8. AGE: Years: 54 Months: 1 Days: 8 If less than one day: hrs. min.

9. Birthplace: Centreville (Town, county, and state) Md.

10. Usual occupation: H/W.

11. Industry or business:

FATHER
12. Name: Richard W. Smoot.
13. Birthplace: Md.

MOTHER
14. Maiden name: Gertrude Zirwest
15. Birthplace: Md.

16. Informant: John Clifton Koenig
Address: 7750 - W. Lanham Hills Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 9-18-1945 (month) (day) (year)
Cemetery or crematory: Wesley Meml. M.E. Ch. Cem.
Location: Prince Frederick, Md.

18. Funeral director: A. N. Chambers Co.
Address: Riverdale Md.

19. 9/15 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/14 1945 at 7.56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1944, to Sept 14 1945 and that I last saw h[illegible] alive on Sept 14 1945

Immediate cause of death	DURATION
Carcinoma of Lung & Uterus	1 yr.
Due to: Metastasis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lemuel R. Brenchley MD
M. D. or other
Address: 1339 - Monroe St. Date signed 9/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

09218

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges.

City or town: Capitol Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years.

Hospital, institution, or street address where death occurred:

613-51st Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Capitol Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 613-51st Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

Charles Franklin Lambert.

3.(b) Social Security Number

579-10-6213.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Florence Mary Lambert

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Dec 12, 1871

8. AGE: Years	Months	Days	If less than one day
73.			hrs. min.

9. Birthplace: Point-of-Rocks Md. (Town, county, and state)

10. Usual occupation: Railroad conductor

11. Industry or business: Railroad

FATHER

12. Name: Chas. Franklin Lambert

13. Birthplace: London County Va.

MOTHER

14. Maiden name: Ella Dwight

15. Birthplace: Point of Rocks Md.

16. Informant: Mrs Florence Lambert

Address: 613-51st Ave, Capitol Hgts Md

17. (Burial, cremation, or removal. Which?) Date thereof: Sept 7 45 (month) (day) (year)

Cemetery or crematory: Addison Chapel

Location: Seat Pleasant Md.

18. Funeral director: Deal Funeral Home

Address: 4612 Ga. Ave NW

19. 9-5-45 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1945 to Sept. 5 1945 and that I last saw h... alive on September 5 1945

	DURATION
Immediate cause of death: Congestive Heart Failure	6 weeks
Due to: Arteriosclerotic Heart Disease.	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Brining M. D. or other

Address: Capitol Heights, Md Date signed: 9/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

09219

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mos., 27 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 4 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: D.C. Home for Aged and Infirm, Blue Plain
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES N LEE

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Jeanette Riley Lee

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): August 7, 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	1	–		

9. Birthplace: Cleveland, Ohio
(Town, county, and state)

10. Usual occupation: Gardner

11. Industry or business:

FATHER
12. Name: Joshua F. Lee
13. Birthplace: West Indies

MOTHER
14. Maiden name: Sarah Agnes Williams
15. Birthplace: Fishkill, N. Y.

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 8 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: McGuire Funeral Home

Address: 1820-9th St. N.W., Wash, D.C.

19. Sept. 7, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7th 1945, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11th 1944, to Sept 7th 1945, and that I last saw him alive on Sept 7th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to	5 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 9/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-Q)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 0922245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
105 Southway Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 Southway Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Nicholas Michael Matyosic — **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 13, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	18	hrs. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Marie Homan
Address: 105 Southway Road

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 9-25-45 (month) (day) (year)
Cemetery or crematory: Mrs. Calvary Cemetery
Location: Harrisburg, Pa.
18. Funeral director: WW Chronister Co
Address: Riverdale, Md.
19. Sept. 25" 1945 (Date rec'd by registrar) James Sevrs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1945 at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Interval between onset and death
Cardiorespiratory renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other
Address: Greenbelt, Md. Date signed: 9-25-45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(163 M)

09221

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Seabrooke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Temporary
Hospital, Institution, or street address where death occurred: Baltimore Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Seabrooke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William O. McKinnish

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife Nora McKinnish
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1884

8. AGE: Years	Months	Days	If less than one day
60	10	0	..... hrs. ..... min.

9. Birthplace North Carolina (Town, county and state)
10. Usual occupation Cab driver
11. Industry or business

FATHER 12. Name James McKinnish
FATHER 13. Birthplace North Carolina
MOTHER 14. Maiden name Alice Whitsonde
MOTHER 15. Birthplace North Carolina

16. Informant Mrs. Gohman
Address Seabrooke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12th 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Balto. Blvd. + D. C. line
18. Funeral director Wm. J. Malley
Address 3200 R. I. Ave. Mt. Rainier Md.
19. Sept. 11 1945 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945 at 12:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
asphyxia	
Due to Acute Carbon monoxide poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9-10-45
Where did injury occur? Seabrooke (City or town) Pg. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Balto Rd
Means of injury Ran exhaust Injured at work? No

Deputy medical examiner
23. SIGNATURE ..... M. D. or Coroner
Address Seabrooke Date signed 9-10-45

2749

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

09222

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince George

City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9743 Baltimore Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Franklin Motherwell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1894

8. AGE: Years	Months	Days	If less than one day
51	6	22	..... hrs. ..... min.

9. Birthplace Huntsville, Alabama
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Machinist

FATHER 12. Name John Motherwell

FATHER 13. Birthplace

MOTHER 14. Maiden name Elizabeth Hill

MOTHER 15. Birthplace Scottsboro, Alabama

16. Informant Mrs. Charles W. Hill (Aunt)

Address 131 Carroll St. S.E., D.C.

17. Cremation Date thereof Sept. 12, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln, Md.

Location Bladensburg Rd.

18. Funeral director W. W. Chambers Co.

Address W. W. Chambers Co. Riverdale

19. Sept 9 1945 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1945, at 9:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19 1945, to 9-7 1945

and that I last saw him alive on 9-7 1945

Immediate cause of death	DURATION
Generalized Carcinomatosis	3 mos. +
Due to Carcinoma of Colon (?)	Unk.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Generalized Carcinomatosis Date of op. 8-20-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Herman D. Slade, M.D.
M. D. or other

Address Riverdale, Md. Date signed 9-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

09223 240 Reg. Diat. No.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brandywine Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Georges

City or town: Brandywine Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Kesley Mitchell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Betty Mitchell

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct 4 - 1857

8. AGE:

Years	Months	Days	If less than one day
87	11	25	hrs. min.

9. Birthplace: Hughesville Chas Co. Md (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER 12. Name: Richard Mitchell

13. Birthplace: Richmond Va

MOTHER 14. Maiden name: Sarah Douglas

15. Birthplace: Richmond Va

16. Informant: Amanda Richardson

Address: 65 - Myrtle St N E Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 13 45 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Benedict Md

18. Funeral director: Hewitt & Ryan

Address: Waldorf Md

19. Sept 11 1945 — (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1945, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1945 to Sept 9 1945

and that I last saw h... alive on Sept. 9 1945

Immediate cause of death — DURATION*

Tetanus Myocarditis — 2 yrs

Due to: Cerebro Sclerosis — 5 Yrs

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John E. Bowers M.D. M. D. or other

Address: Brandywine Md — Date signed 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09224

CERTIFICATE OF DEATH

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: WITHIN CORPORATE LIMITS

County Prince Georges

City or town Jamul Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

819 Main St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince

City or town Jamul Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 819 Main St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Florence Talethia Mullikin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1914

8. AGE: Years 31 | Months 4 | Days 24 | If less than one day hrs. min.

9. Birthplace Grasston Md.

(Town, county, and state)

10. Usual occupation Odd jobs

11. Industry or business Household & yard work

FATHER 12. Name Clarence Stuart Mullikin

13. Birthplace Hall Md

MOTHER 14. Maiden name Martha Burdick

15. Birthplace Johns N. Y.

16. Informant Mrs Clarence E. Mullikin

Address 819 Main St Jamul Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 /45 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location near D C Line

18. Funeral director F Gracchi Sons

Address Hyattsville Md

19. Sept 25 1945 (Date rec'd by registrar) Cora E Wadelton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1945, at 6:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1944, to Sept 25 1945, and that I last saw h alive on Sept 25 1945

Immediate cause of death	DURATION
Rheumatic fever	30 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J McEnroy M D

M. D. or other

Address 402 Main St Jamul Md Date signed 9/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09225

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 829- 25th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: MABEL ODEMMS

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: John R. Odemms
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): October 9, 1916

8. AGE: Years	Months	Days	If less than one day
28	11	-	...hrs. ...min.

9. Birthplace: Shelby, North Carolina (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business:

FATHER
12. Name: Edward Spann
13. Birthplace: Shelby, North Carolina

MOTHER
14. Maiden name: Suzan Montgomery
15. Birthplace: Shelby, North Carolina

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: (month) Sept. (day) 10 (year) 1945

Cemetery or crematory:
Location: Washington, D. C.
18. Funeral director: R. M. Horton
Address: 1322 You St. N.W. Washington D. C.

19. (Date rec'd by registrar) Sept 9 1945 — Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1945, at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/3/45 to 9/9/45 and that I last saw h[illegible] alive on 9/9/45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 Mo.
	2 Da.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09226

CERTIFICATE OF DEATH

★ Reg. Dist. No. 234

1. PLACE OF DEATH
County: Prince George
City or town: Silver Spring, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Acc Life
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo Co
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8651 - River View Rd route 20
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Andrew Jackson Rawn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Amelia Rawn
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 25 1870

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: West Va (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own farm
FATHER 12. Name: George Rawn
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Emma
MOTHER 15. Birthplace: Germany
16. Informant: Archie G. Rawn
Address: 8651 - River View Rd route 20
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 8 - 1945 (month) (day) (year)
Cemetery or crematory: St John's Episcopal
Location: Broad Creek Rd
18. Funeral director: Thomas F. Murray
Address: 2607 - Nichols Ave S E Washington
19. Sept 5 1945 (Date rec'd by registrar) Edward J. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1945 at 5:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to Sept 5 1945
and that I last saw h[illegible] alive on Sept 5 1945

Immediate cause of death	DURATION
Myocarditis	2 yr
Due to: Cerebrovascular accident	2 yr
Due to: Coronary Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Ernst W. Schwartz, M. D. or other
Address: 1225 Talbot St SE Date signed: 9/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (472)

CERTIFICATE OF DEATH

09227

Reg. Dist. No. 2 43

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Geo.

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5600 Allentown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: CHARLES BRENT RAWLINGS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 6 1899

8. AGE:

Years	Months	Days	If less than one day
46			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Self

FATHER — 12. Name: Richard A. Rawlings

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Annie E. Asher

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs. Ruth E. Stant

Address: 1255 York St S.E. DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-21-45 (month) (day) (year)

Cemetery or crematory: Bells Chapel Cemetery

Location: Camp Springs Md

18. Funeral director: D.W. Chambers Co

Address: 517 11th St S.E.

19. Sept. 19 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Sept 18 1945 and that I last saw him alive on Sept 18 1945

Immediate cause of death	DURATION
1. Hemorrhage from Tumor Lesion in Larynx	2 hrs.
Due to Carcinoma of Larynx	1 yr.
Due to	
Other conditions None that I know	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Washington D.C. Date signed: Sept 19 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evi dence for change of year of birth is shown on FLM No. G 98 SEP 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09228

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 hrs. 25 min.
Hospital, Institution, or street address where death occurred: Prince George Hosp.
How long in hospital or institution? 20 hrs. 25 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ... County: ...
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 6th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Robert R. Reese

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife: Julia Slade Reese
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec. 30 1890

8. AGE: Years	Months	Days	If less than one day
54	8	14	... hrs. ... min.

9. Birthplace: Coden Pennsylvania (Town, county, and state)
10. Usual occupation: Guard
11. Industry or business:

FATHER
12. Name: Arthur S. Reese
13. Birthplace: Pa.

MOTHER
14. Maiden name: Hattie O. Whitney
15. Birthplace: Pa.

16. Informant: James G. Reese
Address: 8502 16th ave. Berwyn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17th 1945 (month) (day) (year)
Cemetery or crematory: St. John's Episcopal Church Cemetery Beltsville Md.
Location: ...
18. Funeral director: W. W. Chambers Co.
Address: Riverdale Md.

19. 9/15/1945 (Date rec'd by registrar) Amanda Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1945, at 2:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Sept 14 1945 and that I last saw him alive on Sept 14 1945

Immediate cause of death	DURATION
Hemorrhage Cerebral	
Due to: Arterio Sclerosis	
Due to:	
Diher conditions: Chronic interstitial nephritis. U. Endocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: J. M. Reese M. D. or other
Address: Prince Geo Co Hosp Date signed 9-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 0922 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Avondale - md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. George
City or town: Avondale - md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2035 Woodreeve Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Catharine Slayman Richards

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: William L. Richards
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 24 - 1876

8. AGE: Years	Months	Days	If less than one day
69			hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Slayman Samuel
13. Birthplace: Pa
MOTHER 14. Maiden name: Tate Mary W.
15. Birthplace: Pa
16. Informant: William L. Richards
Address: 2035 Woodreeve Rd. Avondale, md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-15-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Brookland D.C. Colmar Manor Md
18. Funeral director: Lee Chambers Co.
Address: Riverdale, Md
19. [redacted] 19[redacted] (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept - 12 1945, at 2 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 8 1945, to Sept 12 1945
and that I last saw ... alive on Sept 12 1945

	DURATION
Immediate cause of death: Toxic myo - cardosis	5 days
Due to: Probable carcinoma, large bowel -	
Due to:	
Other conditions: Hypertension & cerebral apoplexy	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Shea M. D.
M. D. or other
Address: 4100 - 22nd St. N.E. Date signed: 9/12/45
Wash 18 D.C

09230

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-20)

CERTIFICATE OF DEATH

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince georges

City or town Largo

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

Largo, Marlboro Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Largo

(If outside city or town limits, write RURAL and give nearest town)

Street No. Largo Marlboro Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Ann Richards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife George W. Richards

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March 8, 1878

8. AGE:	Years	Months	Days	If less than one day
	67	6	21	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER — 12. Name William H. White

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Mary M. Cockerey

MOTHER — 15. Birthplace Maryland

16. Informant Edith White

Address Largo, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 / 1 / 45 (month) (day) (year)

Cemetery or crematory St Pauls

Location Baden Md

18. Funeral director Ritchie Bros

Address Upper Marlboro Md

19. Oct 1st 1945 (Date rec'd by registrar) C. Carbaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945, at 5 55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1945 to Sept 29 1945 and that I last saw h.. alive on Sept 21 1945

Immediate cause of death	DURATION
Congestive heart failure	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

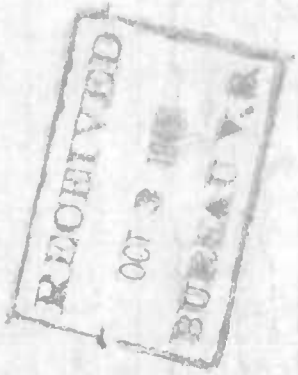
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D. Boyd M.D. or other

Address Forestville Md Date signed 9-29-45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BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

09231

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Seabrook

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rectory & Cooks Lane

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George

City or town Seabrook Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rectory & Cooks Lane

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Howard Seven Robertson

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie Butler Robertson

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 5, 1879

8. AGE:

Years	Months	Days	If less than one day
66	3	5	____ hrs. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Jailer

11. Industry or business County Jail

FATHER 12. Name Wm Robertson

13. Birthplace England

MOTHER 14. Maiden name Sarah Wolford

15. Birthplace Baltimore Md

16. Informant Mrs Annie B Robertson

Address Seabrook Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14, 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colmar Manor Md

16. Funeral director J Gascha Sons

Address Hyattsville Md

19. Sept 14th 1945 (Date rec'd by registrar) Mrs Jack Beaulieu D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 to Sept 10 1945 and that I last saw h-- alive on Sept 10 1945

Immediate cause of death	DURATION
Cancer of Lungs	5 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J McEwen M.D. M. D. or other

Address Laurel Md Date signed 9/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23d

09232

CERTIFICATE OF DEATH

★ Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brandywine, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 weeks

Hospital, institution, or street address where death occurred:

—do—

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: B.

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 516-Old Orchard Road
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Loella Louella Schaefer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas. H. Schaefer

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): September 9- 1864

8. AGE: Years: 81 | Months: 0 | Days: 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: John August Eisenhardt
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Markolf
15. Birthplace: Do Baltimore

16. Informant: Mrs. Frieda Hoffrogge

Address: 516-Old Orchard Road Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17, 1945 (month) (day) (year)

Cemetery or crematory: Lorraine

Location: Baltimore, Md.

18. Funeral director: William Tickner & Sons

Address: Balto. Md.

19. Sept 13 1945 F. H. Billings Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1945, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8th 1945, to Sept 13 1945, and that I last saw her alive on Sept. 13 1945

Immediate cause of death	DURATION
Angina Pectoris	6 days
Due to: Hypertension - Chronic Myocarditis	5 years 6 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: John E. Bowers, M.D.
M. D. or other

Address: Brandywine, Md. Date signed: 9/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09233

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 234

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred: 4401 - Wheeler Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4401 - Wheeler Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florentz Schreiber

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Minnie Schreiber

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1877

8. AGE: Years	Months	Days	If less than one day
67	8	24	....hrs. ....min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired Steamfitter

11. Industry or business

FATHER 12. Name: Nicholas Schreiber

FATHER 13. Birthplace: France

MOTHER 14. Maiden name: Magdalen Zimmermann

MOTHER 15. Birthplace: France

16. Informant: Mrs. Minnie Schreiber

Address: 4401 - Wheeler Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 22-1945 (Month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Maryland

16. Funeral director: Thos. F. Murray

Address: 2007 - Nichols Ave. S.E. Wash D.C.

Sept. 19 1945 Howard I Beall

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h.... alive on ....19....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE: James J. Bourke M. D. or other

Address: 7 Westwell Road Date signed 9-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09234

CERTIFICATE OF DEATH

★ Reg. Dist. No. 237

1. PLACE OF DEATH: Prince George
County ...
City or town ... Aquasco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: ...
How long in hospital or institution? 6

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No. ...
(If rural, give LOCATION)
2.(a) If veteran, name war ...

3.(a) FULL NAME James Oscar Simms

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Sing-d

8.(b) Name of husband or wife: Infant
8.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 9-13-45

8. AGE: Years | Months | Days: 2 | If less than one day: 13 hrs. ... min.

9. Birthplace: Aquasco (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Hastie A Simms
13. Birthplace: Charles Co

MOTHER
14. Maiden name: Bertha L Mitchell
15. Birthplace: Prince George Co Aquasco

16. Informant: Bertha L Mitchell
Address: Aquasco

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-16-45 (month) (day) (year)
Cemetery or crematory: St Marys Cemetery
Location: Bryantown Md
18. Funeral director: Chas McDonald
Address: Hughesville, Md

19. Sept 15th 1945 (Date rec'd by registrar) Mrs Thos B Cortes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13/45, 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/13/45, 19..., to 9/13/45, 19...
and that I last saw h... alive on 9/14/45, 19...

Immediate cause of death	DURATION
Congenital Atelectasis	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Daniel Fletcher M. D. or other
Address Hughesville Md Date signed 9/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09235

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Route # 1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. U. S. Soldiers Home
(If rural, give LOCATION)
2.(a) If veteran, name war: World War ✓

3. (a) FULL NAME: Cabe Snedegar

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1885

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Owingsville, Ky. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Soldier
FATHER 12. Name: Mose Snedegar
13. Birthplace: Ky
MOTHER 14. Maiden name: Phoebe Ann Davis
15. Birthplace: Ky.
16. Informant: Mrs. Lee Palmer
Address: Owingsville, Ky.
17. Transportation (Burial, cremation, or removal. Which?) Date thereof: 9/6/45 (month) (day) (year)
Cemetery or crematory:
Location: Owingsville, Kentucky
18. Funeral director: D. Gasch's Sons
Address: Hyattsville, Md.
19. 9/6 (Date rec'd by registrar) 19 45 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 19 45 at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed skull	
Crushed chest, abdomen, and pelvis	
Due to:	
Other conditions: Compound comminuted fracture of both legs.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9/5/45
Where did injury occur? Cottage City (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route # 1
Means of injury: Hit and run Injured at work? No

Deputy Medical Examiner
23. SIGNATURE: James J. Lord M. D. or other
Address: Forestville, Md. Date signed: 9/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09236

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 3 mos., 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 3 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1237- U. Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LAWRENCE TURNER.

3.(b) Social Security Number: 579-16-1343

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 17, 1917

8. AGE: Years	Months	Days	If less than one day
28	4	1	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Turner
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Allen Belt
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Eugene Ford

Address: 1213 14th St. N.W.

19. Sept. 18, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18th 1945 at 1:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5th 1944, to Sept. 18 1945 and that I last saw him alive on Sept. 18 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs 5 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 9/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09237

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince Georges
City or town: Ritchie Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Pr. Geo. County Almshouse
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pr. Geo County Almshouse
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Zuty

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 15, 1868

8. AGE: Years: 77 | Months: 9 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bohemia, Europe (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER
12. Name: Joseph Zuty
13. Birthplace: Europe

MOTHER
14. Maiden name: Ella ?
15. Birthplace: Europe

16. Informant: Almshouse records
Address: Ritchie, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 3-45 (month) (day) (year)
Cemetery or crematory: Pr. Geo. Co. Alms House
Location: Ritchie, Md.

18. Funeral director: Ritchie Bros.
Address: Upper Marlboro, Md.

19. Sept 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1945, at 1.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943, to Sept 1 1945
and that last saw h.i.m. alive on Aug 31 1945

Immediate cause of death: Myocarditis & Nephritis — DURATION: 2

Due to:

Due to:

Other conditions: Senility

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney M.D. M. D. or other
Address: Cheverly Md Date signed 9-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

09238

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Dillon Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
2707 - 49th Ave Apt 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia (County)
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4059 Alton Ave NE
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME John Henry Vaught

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 22, 1945

8. AGE: Years | Months 4 6 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Ruth Vaught
15. Birthplace Virginia

16. Informant Guy Vaught
Address 2707 49th Ave Dillon Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-5-1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location

18. Funeral director P. L. Saffell
Address 1475 - 48th NE

19. 9-4 1945 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1945 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Tularemia	
Due to Bronchopneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner
Address Forestville Md M. D. or other
Date signed 9-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(1923)

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Chemical

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 days

Hospital, institution, or street address where death occurred:

Prince Georges General

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6502 - 44 Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roy Vawter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Frances Vawter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1902

8. AGE: Years	Months	Days	If less than one day
43	1	5	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Dentist

11. Industry or business

FATHER 12. Name James S Vawter

13. Birthplace Virginia

MOTHER 14. Maiden name Mary Pyle

15. Birthplace Virginia

16. Informant Mrs Frances Vawter

Address 6502 - 44 Ave Hyattsville Md

17. Burial (Burial, cremation, or removal: Which?) Date thereof Sept 12, 1945. (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colmar Manor Md

18. Funeral director F Gaschi sons

Address Hyattsville Md

19. 9/11 1945 Amanda Dumay

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945, at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute Congestive heart failure	
Due to Hypertension	
Due to Gun shot wound of head	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 9-9-45

Where did injury occur? Hyattsville P.G. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In his office

Means of injury Gun-shot, injured at work? No

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville Md Date signed 9-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09240

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Hedley Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Langs Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hedley Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Langs Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Walters

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2, 1945

8. AGE: Years	Months	Days	If less than one day
	2	17	hrs. min.

9. Birthplace Washington DC

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Joseph Walters

13. Birthplace Md

MOTHER 14. Maiden name Victoria Fredrickson

15. Birthplace Minn.

16. Informant Victoria Walters

Address 1178 Monroe St. N.E. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colmar Manor Md

18. Funeral director J. Gash Sons

Address Hyattsville Md.

19. 9/21 (Date rec'd by registrar) 1945 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19, 1945 at 7:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Suffocation in bed clothing	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 9-19-45

Where did injury occur? Hedley Park P.G. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Asphyxia in bed clothing Injured at work? No

Deputy Medical Examiner

23. SIGNATURE ..... M. D. or other

Address Upper Marlboro Md Date signed 9-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

19241

★ Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 8 months, 14 days
Hospital, Institution, or street address where death occurred: 10-P Southway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 18-P Southway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MAY GERTRUDE WEIGLE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Herman Weigle
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 21, 1883

8. AGE: Years	Months	Days	If less than one day
62	1	23	..... hrs. ..... min.

9. Birthplace: BOILING SPRINGS, Pa.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: George Washington Rank
13. Birthplace: Unknown (Va)
MOTHER 14. Maiden name: Mary Ann Aulthouse
15. Birthplace: Unknown (Va)
16. Informant: daughter: Mrs. Evelyn E. Green
Address: 18-P Southway, Greenbelt
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-16-45 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Church Tacoma Pa.
18. Funeral director: Wm Chambers Co
Address: Riverdale, Md
19. Sept 15" 1945 (Date rec'd by registrar) James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14, 1945 at 6:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12, 1945 to Sept. 14, 1945
and that I last saw her alive on September 14, 1945

	DURATION
Immediate cause of death: Bronchus Carcinoma	1 year
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Lewis Wodak, M.D.
M. D. or other
Address: 30-D Ridge Rd, Greenbelt Md Date signed 9-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 5 mos., 17 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs., 5 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 514 - 25th Place N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: Whitlock Joseph W

3. (b) Social Security Number: 578-14-2374

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 29, 1908

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
37	–	14		

9. Birthplace: Mullin, South Carolina (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business:

FATHER
12. Name: Warren Whitlock
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Anna Price
15. Birthplace: South Carolina

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 13-1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: McDevitt & Schey
Address: 424 E. St. N.W.

19. Sept. 12 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1945, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/26 1945 to 9/12 1945 and that I last saw him alive on 9/12/1 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis for advanced	4 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 9/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Woodbridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAMS, Addine

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (sep.)

6.(b) Name of husband or wife: Johnny F. Williams
6.(c) If alive, give age: 2 years

7. Birth date of deceased (mo., day, yr.): July 5, 1918

8. AGE: Years	Months	Days	If less than one day
27	2	16	hrs. min.

9. Birthplace: Woodbridge, Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Manuel Fisher
13. Birthplace: Woodbridge, Virginia

MOTHER
14. Maiden name: Carrie Cole
15. Birthplace: Pennsylvania

16. Informant: Decedent
Address:

17. Disposition: Removal to Cocoquan Va. Date thereof 9-21-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Cocoquan Va.
Location: Same
18. Funeral director: Ed Lasch
Address: Bladensburg, Md.

19. Sept 21 1945 Rowland S Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 21, 1945, at 3:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5, 1945, to Sept. 21, 1945 and that I last saw h[illegible] alive on September 21, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	11 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15